

FAILURE TO THRIVE

(134)

PARTICIPANT TYPE.....	INFANTS, CHILDREN
HIGH RISK.....	YES

RISK DESCRIPTION:

Presence of failure to thrive (FTT) diagnosed by a physician as self-reported by applicant, participant, or caregiver; or as reported or documented by a physician, or someone working under physician's orders

ASK ABOUT:

- Birth status including prematurity and birth weight
- Growth history (especially if the WIC record has limited information about previous measurements); the circumstances when growth began to falter
- Chronic medical conditions that affect metabolic needs and ability to consume an adequate diet including conditions that:
 - Increase metabolic needs (e.g., cystic fibrosis, anemia, lead poisoning, congenital heart disease, chronic renal insufficiency, recurrent respiratory infections, bronchopulmonary dysplasia, HIV/AIDS)
 - Make adequate intake difficult due to oral-motor dysfunction (e.g., cleft palate, esophageal strictures, pyloric stenosis, central nervous system dysfunction, gastroesophageal reflux, dysfunctional eating skills, hypersensitivity and oral aversion)
 - Result in increased gastrointestinal losses (e.g., cystic fibrosis, short gut, malabsorption, chronic diarrhea, inflammatory bowel disease, food allergy)
 - Alter metabolic needs (e.g., inborn errors of protein, carbohydrate, or fat metabolism)
 - Are associated with poor growth (e.g., Fetal Alcohol Syndrome)
- Special diets and medications used to treat identified medical conditions
- Recent or recurrent illnesses affecting nutritional status
- Access to ongoing health care and attendance at well child visits
- Oral health status and ability to eat age-appropriate foods
- Family, religious or cultural issues affecting child feeding practices
- The child's developmental feeding skills in relationship to child's age
- Parent and caregiver's knowledge about child nutrition, normal toddler and preschool feeding behaviors, hunger cues, and the division of responsibility in feeding
- Feeding problems and the parent's coping strategies (i.e., is the parent overly permissive or overly restrictive?)
- Parent's social support system

Revised January 2011

Developed October 2007 by the Iowa WIC Program

ASK ABOUT (CON'T):

- Family and household environment including the social and psychological environment (e.g., chaotic, highly distractible, disorganized), depressed parents or caregivers, parental substance use or abuse
- Number and identity of caregivers responsible for feeding and food preparation

Note: Failure to thrive is a symptom of other problems. If the underlying problem is unclear, follow-up with the physician so that appropriate counseling can be provided.

NUTRITION COUNSELING/EDUCATION TOPICS:

- Explain the relationship between good nutrition and normal growth and development.
- Reinforce any special diet and feeding instructions the physician or clinical dietitian provided to the participant.
- Describe typical appetite and growth patterns for infants and young children.
- Identify normal infant, toddler and preschooler eating behaviors.
- Review relevant, age-appropriate feeding guidelines including:
 - Frequency of feedings (breastfeeding and formula)
 - Proper formula dilution and sanitary formula preparation
 - Introduction of solid foods when developmentally ready (for premature infants, consider adjusted age and developmental readiness)
 - Parent's awareness of hunger and satiety cues
 - Provide adequate number of servings from each food group.
 - Provide age-appropriate serving sizes and textures of food.
 - Discuss strategies to increase the caloric density of the diet including adding nuts, dried fruit, dry milk powder, grated cheese and other ingredients.
 - Replace calorie-free foods with nutrient-dense food choices that provide calories.
 - Offer regular meals and snacks. Consider five or six small meals rather than two or three large meals.
 - Discuss the division of responsibility in feeding. Encourage the parent to allow the child to decide how much to eat.
 - Identify ways to foster a pleasant mealtime environment and to limit distractions during meals and snacks.
 - Identify strategies for sharing information with all caregivers responsible for feeding and food preparation.

Note: Some topics may not be appropriate for infants and children with oral-motor feeding problems and those who are tube-fed.

POSSIBLE REFERRALS:

- If the child is not receiving well child care or keeping appointments, refer the child (if on medical assistance) to Health Tracks (<http://www.nd.gov/dhs/services/medicalserv/health-tracks/>), the local public health department, or primary care providers in the community.
- If access to sufficient food is a concern, refer to other food assistance programs such as SNAP, local food pantry, etc.
- If oral health status is affecting the child's ability to consume an adequate diet, refer to a local dental office, the local public health department (public health hygienists) or Health Tracks (if on medical assistance) for additional screening and referral. More information about oral health services in ND can be found at <http://www.ndhealth.gov/oralhealth/>.
- If the household and family situation is so disordered that establishing a normal feeding relationship is unlikely, refer the family to local public health department, a feeding team that works with children, or social service agency.
- If parental substance use or abuse is a concern, refer to community resources and treatment centers.
- Refer the child to the Right Track Program for early intervention services (<http://www.nd.gov/dhs/services/disabilities/earlyintervention/parent-info/right-track.html>).
- Depending on the child's medical condition(s), a referral to Children's Special Health Services (<http://www.ndhealth.gov/cshs>) may be an option.